SMD
Topics in Chirurgia d'urgenza

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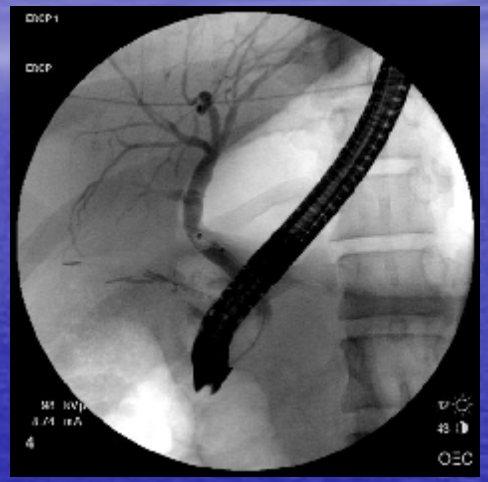
ERCP and acute gallstones pancreatitis

- ü Urgent ERCP (within 24 hours) should be performed in patients with gallstone pancreatitis who have concomitant cholangitis.
- ü Early ERCP (within 72 hours) should be performed in those with a high suspicion of a persistent common bile duct stone (visible common bile duct stone on noninvasive imaging, persistently dilated common bile duct, jaundice).



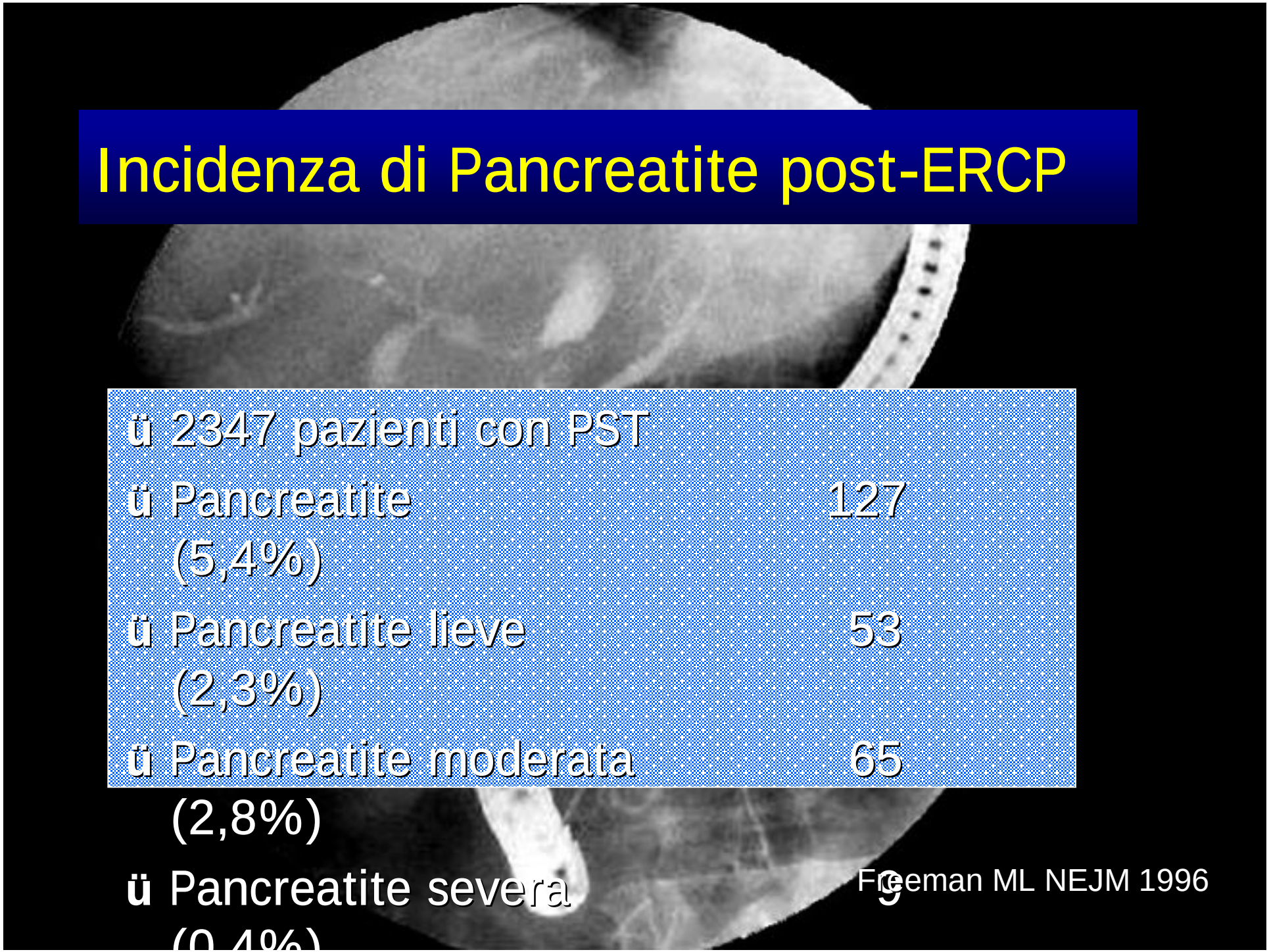
- ü Endoscopic sphincterotomy in the absence of choledocholithiasis at the time of the procedure is a reasonable therapeutic option, but data supporting this practice are lacking.
- ü Early ERCP in those with predicted or actual severe gallstone pancreatitis in the absence of cholangitis or a high suspicion of a persistent common bile duct stone is controversial

The role of endoscopy in the evaluation of suspected choledocholithiasis

6. We recommend against early ERC in the evaluation and management of patients with mild ABP in the absence of clear evidence of a retained stone. 444B
7. We recommend early ERC in patients with acute biliary pancreatitis and concomitant cholangitis, given the observed benefits in morbidity and mortality. 4444
8. We suggest that patients with acute biliary pancreatitis and clinical evidence of biliary obstruction be considered for early ERC. 44BB

   We cannot recommend for or against early ERC in patients with predicted severe acute biliary pancreatitis in the absence of overt biliary obstruction or cholangitis, given the lack of consensus in the available data. 44BB
9. As patients with acute biliary pancreatitis are at least at intermediate risk for choledocholithiasis, we suggest pre-operative EUS or IOC be considered for these patients when cholangitis or biliary obstruction are absent. 44BB

Incidenza di Pancreatite post-ERCP



ü 2347 pazienti con PST	
ü Pancreatite (5,4%)	127
ü Pancreatite lieve (2,3%)	53
ü Pancreatite moderata (2,8%)	65
ü Pancreatite severa (0,4%)	9

Freeman ML NEJM 1996

Fattori di rischio della pancreatite post-PST

Fattori di rischio	Pz con pancreatite 127	Pz totali 2347	P univariato	Odds Ratio(95%CI)
Sospetta SOD n (%)	52(41)	272(12)	<0,001	5,01(2,73-9,22)
Età anni	51,7±17,8	60,4±19,1	<0,001	2,14(1,41-3,25)
Precut n (%)	17(13)	111(5)	<0,001	4,34(1,73-10,88)
Difficoltà di incannulamento	1,9±0,8	1,4±0,7	<0,001	2,40(1,07-5,36)
N°iniezioni dotto pancreatico	3,5±3,9	1,8±2,9	<0,001	1,35(1,04-1,75)

Prevention of post ercp pancreatitis

- ERCP should be avoided if alternative diagnostic tests (in particular, CT, magnetic resonance cholangio-pancreatography, or EUS) can provide similar diagnostic information.
- ERCP should be performed by endoscopists with appropriate training and experience.
- Informed consent must provide the patient with a realistic assessment of both risk and expected benefit.
- Endoscopists performing ERCP should have the technical skill and familiarity to place pancreatic duct stents in situations of high risk for post-ERCP pancreatitis

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CLINICAL—PANCREAS

A Conservative and Minimally Invasive Approach to Necrotizing Pancreatitis Improves Outcome

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Table 3. Mortality in the Different Subgroups of the 639 Patients With Necrotizing Pancreatitis

Subgroups	Mortality
All patients with necrotizing pancreatitis	93/639 (15)
Pancreatic necrosis	64/324 (20)
Peripancreatic necrosis alone	29/315 (9)
No organ failure	8/399 (2)
Organ failure	
At any time during admission	85/240 (35)
At any time during admission, persistent	77/213 (36)
In the first week of admission	57/140 (41)
Multiple organ failure	
At any time during admission	79/194 (41)
At any time during admission, persistent	66/161 (41)
In the first week of admission	44/94 (47)
Infected or sterile necrosis	
Primary infected necrosis	41/202 (20)
Sterile necrosis	52/437 (12)
Conservative treatment or intervention	
Conservative treatment	28/397 (7)
Any intervention (ie, emergency laparotomy, drainage, necrosectomy)	65/242 (27)
Emergency laparotomy	25/32 (78)
Any intervention for suspected or confirmed infected necrosis	40/208 (19)
Catheter drainage as first intervention	26/130 (20)
Necrosectomy as first intervention	14/78 (18)
Necrosectomy (with or without previous drainage or emergency laparotomy)	41/169 (24)
Any operation (ie, necrosectomy or emergency laparotomy)	56/187 (30)